A. COORDINATION OF BENEFITS

The Wisconsin Medical Assistance Program (WMAP) is the payer of last resort for any WMAP covered service. If the recipient is covered under health insurance, the WMAP reimburses that portion of the allowable cost remaining after all health insurance sources have been exhausted. Refer to Section IX of Part A of the WMAP Provider Handbook for more detailed information on services requiring health insurance billing, exceptions, and the "Other Coverage Discrepancy Report."

B. MEDICARE/ MEDICAL ASSISTANCE DUAL ENTITLEMENT

Recipients covered under both Medicare and Medical Assistance are called dual-entitlees. Claims for Medicare covered services provided to dual-entitlees must be billed to Medicare prior to billing Medical Assistance.

If the recipient is covered by Medicare, but Medicare denied the claim, a Medicare disclaimer code must be indicated on the claim, as indicated in the claim form instructions in Appendix 2 of this handbook.

C. QMB-ONLY RECIPIENTS

Qualified Medicare Beneficiary Only (QMB-only) recipients are only eligible for WMAP payment of the coinsurance and the deductibles for Medicare-covered services. Since Medicare does cover some medical day treatment services, claims submitted for QMB-only recipients for Medicare allowed services may be reimbursed.

D. BILLED AMOUNTS

Providers must bill the WMAP their usual and customary charge for services provided. The usual and customary charge is the amount charged by the provider for the same service when provided to private-pay patients. For providers using a sliding fee scale for specific services, usual and customary means the median of the individual provider's charge for the service when provided to non-Medical Assistance patients. Providers may not discriminate against Medical Assistance recipients by charging a higher fee for the service than is charged to a private-pay patient.

Medical day treatment services are subject to recipient copayment as noted in Appendix 4 of this handbook. The billed amount should not be reduced by the amount of recipient copayment. The applicable copayment amount is automatically deducted from the WMAP-allowed payment.

E. CLAIM SUBMISSION

Paperless Claim Submission

As an alternative to submission of paper claims, EDS is able to process claims submitted on magnetic tape (tape-to-tape) or through telephone transmission via modem. Claims submitted electronically have the same legal requirements as claims submitted on paper and are subjected to the same processing requirements as paper claims. Providers submitting electronically can usually reduce their claim submission errors. Additional information on paperless claim submission is available by contacting the Electronic Media Claims (EMC) Department at:

EDS
Attn: EMC Department
6406 Bridge Road
Madison, WI 53784-0009
(608) 221-4746

A Paperless Claims request form can be found in Appendix 3 of this handbook.

E. CLAIM SUBMISSION (continued)

Paper Claim Submission

Medical day treatment services must be submitted using the National HCFA 1500 claim form. A sample claim form and completion instructions are in Appendices 1 and 2 of this handbook.

Medical day treatment services submitted on any other paper form than the National HCFA 1500 claim form are denied.

The National HCFA 1500 claim form is not provided by the WMAP or EDS. It may be obtained from a number of forms suppliers. One such source is:

State Medical Society Services
Post Office Box 1109
Madison, WI 53701
(608) 257-6781 (Madison area)
1-800-362-9080 (toll-free)

Completed claims submitted for payment must be mailed to:

EDS
6406 Bridge Road
Madison, WI 53784-0002

Submission of Claims

All claims for services rendered to eligible WMAP recipients must be received by EDS within 365 days from the date such service was rendered. This policy pertains to all initial claim submissions, resubmissions, and adjustment requests.

Exceptions to the claim submission deadline and requirements for submission to Late Billing Appeals are in Section IX of Part A of the WMAP Provider Handbook.

F. DIAGNOSIS CODES

All diagnoses must be from the International Classification of Diseases, 9th Edition, Clinical Modifications (ICD-9-CM) coding structure.

Claims received without the appropriate ICD-9-CM code are denied.

The complete ICD-9-CM code book can be ordered by writing to the address listed in Appendix 3 of Part A of the WMAP Provider Handbook.

Providers should note the following diagnosis code restrictions:

- Codes with an "E" prefix must not be used as the primary or sole diagnosis on a claim submitted to the WMAP.
- Codes with an "M" prefix are not acceptable on a claim submitted to the WMAP.

G. PROCEDURE CODES

HCFA Common Procedure Coding System (HCPCS) codes are required on all medical day treatment claims. Claims or adjustments received without HCPCS codes are denied. Allowable HCPCS codes and their descriptions for medical day treatment are listed in Appendix 4 of this handbook.

The functional assessment procedure codes are subject to the six hour per two year limit on mental health evaluations. Functional assessments which cause this limit to be exceeded should be billed using the limitation-exceeded functional assessment codes.

H. PLACE OF SERVICE AND TYPE OF SERVICE CODES

Allowable place of service and type of service codes for medical day treatment services are included in Appendix 5 of this handbook.

I. FOLLOW-UP TO CLAIM SUBMISSION

It is the provider's responsibility to initiate follow-up procedures on claims submitted to EDS. Processed claims appear on the Remittance and Status Report either as paid, pending, or denied. Providers are advised that EDS will take no further action on a denied claim until the information is corrected and the claim is resubmitted for processing. If a claim was paid incorrectly, the provider is responsible for submitting an adjustment request form to EDS. Section X of Part A of the WMAP Provider Handbook includes detailed information regarding:

- the Remittance and Status Report;
- adjustments to paid claims;
- return of overpayments;
- duplicate payments;
- denied claims; and
- Good Faith claims filing procedures.